



**PATIENT INFORMATION**

First Name \_\_\_\_\_ (MI) \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Age \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security# \_\_\_\_\_ Sex \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer & Address \_\_\_\_\_  
Email Address \_\_\_\_\_ Marital Status ( S M D W ) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Phone \_\_\_\_\_ Referred By \_\_\_\_\_

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**YOUR AUTO INSURANCE INFORMATION:**

Name of Insured \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Phone# \_\_\_\_\_ Adjuster \_\_\_\_\_ Claim# \_\_\_\_\_

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**THEIR AUTO INSURANCE INFORMATION:**

Name of Insured \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Phone# \_\_\_\_\_ Adjuster \_\_\_\_\_ Claim# \_\_\_\_\_

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**ATTORNEY INFORMATION:**

Attorney Name \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_

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What is your major complaint? \_\_\_\_\_

Is this condition due to an: A) Auto Accident B) Slip & Fall C) Other Accident D) Work

Are the Symptoms: A) Improving B) Getting Worse C) About the same

Date of Injury \_\_\_\_\_ Date Symptoms Appeared \_\_\_\_\_

Have you had these symptoms before? ( Y / N ) If so when? \_\_\_\_\_

Have you seen another doctor for this condition? ( Y / N )

Drs. Name \_\_\_\_\_ Date Consulted \_\_\_\_\_ Diagnosis \_\_\_\_\_

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_